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ABSTRACT

This analysis of the National Certifying Examination for Operating Room Technicians revealed that examinee's performance was related to their educational preparation. Utilizing test results from 2,841 candidates, the performance of first time candidates was compared to the performance of graduates of one or two-year programs and of technicians who received on-the-job training. The failure rate was lowest for the first-time candidates; the risk of failure increased each time the examination was repeated. Job-trained technicians had a higher failure rate as a group. With respect to formal training, two-year program graduates had a higher performance level. Analysis of the scores in each content area of the examination indicated that although there were significant differences in scores between program graduates and job-trained technicians, the strong and weak content areas were essentially the same for all groups. A series of recommendations include general guidelines and suggestions for technician training programs, a list of behavioral objectives for the content areas identified as difficult, and topics to be considered for future research. (BH)

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AN ANALYSIS OF THE NATIONAL CERTIFYING EXAMINATION FOR OPERATING ROOM TECHNICIANS

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INTRODUCTION

The Operating Room Technician

The Operating Room Technician, as a para-professional in health care, came into being in the Armed Forces during World War II to meet the demand for specialized personnel in our field hospital operating rooms. The Operating Room Technician was usually a"medic" who had additional preparation in operating room procedures.

After the war, as the role of surgery increased, and not enough nurses were available to meet this need, this concept of the technician was transferred to civilian hospitals.

Candidates usually were up-graded aides or orderlies. "Curriculum " ranged from on-the-job training to formal six-week to six-month work/study programs. Since most programs were developed to meet individual hospital staffing needs, curriculum, if any, usually was limited to the focus of surgery in that department. That is, if a hospital did not "do" eye surgery, eye surgery was not part of the curriculum.

As can be imagined, this form of education, with curriculums of varying length and quality, limited OR Technicians in performance areas. Also limited was

the OR Technician's mobility, since many hospitals would only hire technicians whom they had trained, or those from local programs, whose "curriculums" they knew.

AORN/AORT

By the early sixties it was apparent that this "hodge-podge" form of education was neither meeting the needs of hospitals nor technicians. Through the Association of Operating Room Nurses (AORN) a "Manual for Teaching the Operating Room Technician" was published in 1967. This established a base content for all ORT programs.[1]

In 1969, under the sponsorship of AORN, the Association of Operating Room Technicians (AORT) was formed. AORN/AORT worked closely together for several years.

"The Essentials"

In 1972, The ORT program curriculum base was expanded in the "Essentials ofan Approved Program for the Operating Room Technician", established by the AMA Council on Medical Education (see Appendix 1), whose recognition the AORT had sought. Accredition of OR Technician programs was begun in 1975. As of April 1977, there were 46 accredited programs, 12 pending accreditation,and 182 in process of being reviewed.[2]

Certification

The next step, once standards for curriculum were established, was a testing mechanism to insure the quality of the graduate practioners.

A certification examination was first developed by an AORN/AORT committee in 1969, and administered in December 1970, under the auspices of AORT.

In 1973, after a review of the examination, and questioning the validity/credibility of a professional association testing itself, the AORT Board of Directors appointed an independent committee, The Liaison Council on Certification (LCC) to develop a certification process.

The Liaison Council on Certification is responsible for all aspects of the examination: financial, policy, and administrative. It reviews and approves each examination before administration.

The Liaison Council appointed an Exam Writing Committee (EWC) to develop the test outlineand content, and items which apply to the content areas.The Liaison Council also contracted with The Psychological Corporation, a professional testing agency, to assist the Exam Writing Committee in item development, and administer the examination. The first of its examinations was administered in June 1976.

The Certifying Examination consists of 250 multiple-choice itemscovering five basic categories related to Operating Room practice: Basic Sciences, Patient Care, Aseptic Technique and Environmental Control, Supplies and Equipment, and Surgical Procedures, (see outline, Appendix 2)

The examination outline was developed by the Exam Committee Writing, and approved by the Liaison Council on Certification.

The content is based on data drawn from the "Essentials", ORT Programs, and standard textbooks used in the field.(see "Guidelines for Test Specifications" Appendix 3)

The items(questions) on the examination are not originally written by the Exam Writing Committee, but are developed from items submitted by ORT instructors from all over the country. The EWC takes these items, which reflect what is being taught in the schools, reviews them for content, clarity, choice of options, correctness of answer,and regional terms. By editing, it tries to develop the clearest, fairest items possible. The item is then assigned to a category on the exam outline, and placed in the test pool.

As new examinations are devised, items are pulled from the pool using exam outline allocations.

A candidate must score 70 % (175) on the overall examination, with no less than a score 60% in each category, in order to become certified.

Focus of the Study

Licensure by government agencies, or certification/ registration by professional associations, has long been recognized as a legitimate form of proof of compentency to practice in the health professions. Although the certification of Operating Room Technicians is currently voluntary, it has won wide acceptance as proof of competency for entry level practice. Many hospitals already require certification ac a condition of employment, and it is generally accepted that mandatory certification is not too far off.

The focus of this study will be the national Certifying Examination for Operating Room Technicians.

Delimitations - The study will focus on the examinations administered by The Psychological Corporation in June 1976, December 1976, and March 1977 to a total of 2,841 candidates.

Our emphasis will be on the performance of first time candidates (2,276), with a comparison study of the performance byone year program graduates (1,579), and on-the-job trained technicians(270).

Need for the Study

A need for this study has developed from several areas:

The Education Department of AORT - This department works closely with ORT programs, and the membership of AORT. It is responsible for the development of Continuing

Education programs for the members, and its director serves as a member of the Joint Review Committee for Accreditation of ORT Programs.

Any information which indicates the strengths and/or weaknesses of entry level technicians will be a resource tool for this department.

The ORT Programs - Many programs, concerned over their graduates pass/fail rates on the examination, are seeking more specific information about candidate performance.

Schools and examinees receive information about total scores, and scoresin major content areas, but breakdown of performance within these areas has not been available.

There is not,at the moment, a detailed outline of curriculum objectives for programs, the "Essentials" being very broad in scope. Schools often use exam performance as "evaluation" of their curriculum. It is hoped that more specific instructional objectives will be disseminated to the programs within the next few years. For the present, identifying areas of difficulty on the exam for past candidates will at least give the programs a place to start when reviewing their curriculum.

The Uncertified Technician - Those candidates presently employed who wish to take the certification examinationare often at a loss as to what to study, and

where to get the materials required.

The Liaison Council on Certification and the AORT Education Department are working toward developing a detailed study guide and reference library, as well as educational programs.

Again, pending development of a complete "package", identifying areas of difficulty on the exam will pinpoint the content which needs priority treatment.

National Commision[5] for Health Certification Agencies - In 1976, a federal report, "A Proposal for Credentialling Health Manpower"[3], was issued by the Department of Health, Education, and Welfare (HEW), suggesting the development of a unified credentialling process for all Allied Health Professions. In response to this proposal a steering committee for a National Commission for Health Certification Agencies was formed. The Executive Office of AORT and the Liaison Council on Certification have participated in these meetings.

The purpose of the Commission has been recommended to be as follows: " To establish standards, grant recognition tocertifying bodies, and monitor adherance to those standards for certification of individuals participating in health care delivery systems, thus promoting accountability." (see Appendix 4)

Information gathered from this research should be of value when comparing our examination to the standards

for certification established.

There has been no previous research of the type proposed on the national Certifying Examination for Operating Room Technicians. According to Sallyann Henry, Ph.D., Associate Director, Professional Examinations Division, The Psychological Corporation, there has been no such in depth research done on any of the eleven health-related occupations currently tested by their agency.

Most group's exam writing committees routinely review the major test statistics - mean, standard deviation, reliability coefficients, etc. They also scan through item statistics, reviewing in depth those items whose statistics"stand-out", that is, extremely high or low difficulty levels, and negative correlations on correct answers. These items are reviewed again, and, if necessary, revised or removed from the test pool. Previously developed items are also reviewed by the exam writing committees each time a new examination is developed.

Purpose of the Study

This research has been initiated for two primary purposes:

1. To identify, through item analysis, the following:

a. Which content areas of the certifying

examination are of greatest difficulty for OR Technicians as a whole.

b. Which content areas of the certifying examination are of least difficulty for the OR Technicians as a whole.

c. If there are any differences in area of difficulty between on-the-job trained technicians and graduates of formal one year programs.

2. Based on the data revealed, recommend guidelines/objectives which will permit:

a. Formal programs to upgrade their curriculums.

b. Continuing Education programs to be developed to upgrade the working ORT.

Secondarily, it is expected that some of the data revealed in this study will become a resource for information for new examination development by the Exam Writing Committee.

It may also be useful when evaluating the examination against the standard certification patterns to be developed by the National Commission of Health Credentialling Agencies.

PROCEDURES

Introduction to Item Analysis

Item analysis is defined as the application of statistical techniques to assess two characteristics of items (questions), their difficulty, and their discriminating power.[4] It often includes a study of the responses to all items.

Gronlund[5] says that item analysis is designed to answer such questions as the following:

"1. Does the item function as intended?

   a. Did the norm-referenced test items adequately discriminate between high low achievers?

   b. Did criterion-referenced test items adequately measure the effects of instruction?

2. Were the test items of appropriate difficulty?

3. Were the test items free of defects?

4. Were the distracters effective(in multiple-choice items)?"

Item analysis can be of value in several ways:

1. It can provide a basis for classroom instruction(for teacher developed tests).

2. It can provide a basis for planning remedial work by bringing to light areas of weakness, and making it possible to focus instruction on particularly weak areas.

3. It can provide a basis for general improvement of classroom instruction. Information derived can be used to evaluate curriculum content, and suggest curriculum revision or shifts in teaching emphasis.

4. It can lead to increased skill in test construction.[6]

Also to be considered when reviewing an item are the following:

5. Was the item stated in simple, clearlanguage?

6. Was the item free from clues?

7. Was the item independent of other items?

8. Did the items provide adequate coverage of the test specifications (announced content areas)?[7]

An item may be considered technically effective if the following occur:

1. More high scorers than low scorers got it right.

2. All wrong options attracted some candidates.

3. Wrong responses attracted more low scorers than high scorers.[8]

All of the above being present the most important consideration then becomes does the item measure an important learning outcome (as stated in the test specifications).[9]

Source of Data

All data in this study is based on information gathered from the files of The Psychological Corporation, the administrator of the certifying examination. The following data were supplied:

1. Copies of the Certifying Examinations for June 1976, December 1976, and March 1977.

2. Examination content area codes for each item on each examination.

3. Computer print-outs for each examination, for the following groups:

T -Total group - all first time candidates, from various educational backgrounds, who took the examination.
N = 6/76 -908, 12/76 -998, 3/77 - 380

P -Program group- all first time candidates who graduated from one year programs.
N = 6/76 - 669, 12/76 - 679, 3/77 - 231

J -Job group - all first time candidates who indicated on-the-job training as their educational preparation.
N = 6/76 - 64, 12/76 -108, 3/77 - 98

Definition of Terms[10] - Each computer print-out contained the following information for its group:

1. Mean - average raw score

2. Standard Deviation - measure of spread of scores on the examination

3. Performance Data, by option*, for High, Mid, Low, and Total group score.

High - The 27% who received thehighest score on the examination

Mid - The middle 46%

Low - The lowest 27%

Total -The total percentage of the group who chose that option.

*Data by option - On the print-out, each item on the examination is listed, in numerical order. Under each option (answer choice)is shown the number of candidates in that group (high,mid, low), who chose that item. A second column under each option indicates the percentage of the group represented by the number in the first column.

4. Summary of item statistics - an item by item listing of the high, low, and total**percentages who chose the correct answer on each item.

** The total percentage score of those who answer an item correctly indicates the difficulty index (level) of an item. The lower the index, the more

difficult the item. This is also known as the p-value.

5. Flan R - the discrimination index (r-value) - The ability of an item to discriminate between high and low scorers. The higher the r-value (from 0 to + or -1) the greater the discriminating power of the item.

The r-value should discriminate positively (0 to +1) for the correct answer. That is, more high scorers than low scorers should have chosen the correct answer.

The incorrect options (distracters) ideally should show a negative r-value (0 to -1). That is, more low scorers than high scorers should have have chosen the wrong option.

6. KR20 and KR21 (Kuder-Richardson Formula) - Formulas for estimating the reliability of a test based on inter-item consistancy. The nearer the score to 1.0 the greater the reliability of the examination.[11]

For the purposes of this project items of greatest difficulty are those which range at or below the 40% level, and items of least difficulty (easy) are those at or above the 81% level.

The rationale for this choice of levels is based on Adkins[12] which states that the ideal level of difficulty for an item is about 50%, the point at which it discriminates best.It is suggested that for multiple-

choice items this level be adjusted upward, that a four-response item should ideally be between 60-62%.

Using 60% as a middle area, this writer elected to investigate those items which fell twenty percent or more above and below that level.

Methodology

Copies of the Certifying Examinations for June 1976, December 1976, and March 1977 were obtained. Each item was cut out and pasted ona 5x8 index card. (750 items).

Each item card was coded as to which content area of the examination it tested. From the computer print-outs to each item card was transferred the following item statistics:

a. The high ,low, and total percentage scores for the Total, Program and Job groups. (difficulty level)

b. Flan R (r-value) on each item for each group

c. Performance data, by option , for each group

Each examination was separately reviewed and then compared. By sorting and re-sorting the cards in each examination, using the different datum recorded, one was able to identify the specific information sought.

The cards were first sorted into levels of difficulty, i.e., 11-20%, 21-30%, etc. By counting the cards in a percentage level one had the total number of items in that level. Each level was further sorted by content

area on the examination, counted and recorded.

By using graph paper, and listing the content areas along the vertical axis, and the difficulty level intervals along the horizontal axis, the frequency of item occurence at each level, for each specific content area, was coded in for the three examinations. One now had a visual representation of the three examinations, and could identify strong and weak patterns almost at a glance.

Concentrating on those items which had a difficulty level at or below 40%, several charts/tables were developed, each summarizing the data in the one previous to it.

First, after counting the item cards, a table was drawn up which indicated the exact number of items from each specific content area of the test outline at or below 40% difficulty level. This was done for Total, Program, and Job groups, for each examination.

Second, these numbers were summarized into a second set of tables which indicated the percentage of items at or below 40% in each sub-category of the major content areas (Anatomy and Physiology, Microbiology,etc,) for each group, on each examination.

Third, the second set of charts were summarized into one chart, comparing the three groups (T,P,J) on the

three examinations, in the five major content areas, by percentage of items with a difficulty level at or below 40 (Table 4).

Items above the 80% level(easy) were also reviewed in a similar manner as the difficult. A table comparing percentage of items in the "difficult" and "easy" categories, by major content area, was developed.(Table 5)

Performance data, by option, on all items in the "difficult" level were also reviewed on each examination. Comparison of scores for the Total, Program, and Job groups were made. Each item was analyzed and coded as to its testing objective, using the taxonomies of Bloom.[13]

All options were reviewed for their r-value - correct answers to discriminate positively, distracters negatively. The percentage of the group who chose each option was noted. presumptions were made as to why distracters were chosen over the correct answer.

Items which gave questionable statistics were re-checked in several texts for accuracy.

Any items which were repeated in any of the three examinations were compared by their item statistics on each exam.

Mean scores for the total exam and major content areas were compared for the Program and Job groups, and tested at the .01 significance level for each examination. (Table 1)

ANALYSIS OF DATA WITH DISCUSSION OF FINDINGS

Comparison of Mean Scores, Pass/Fail Rates

A comparison of performance by the mean scores of the Program and Job groups (Table 1) revealed the following (calculated at the .01 significance level):

1. Thereis a significant difference in the overall performance between Program and Job groups. The Program group scored higher on all three exams.

2. Program graduates tend to perform significantly better in all major content areas of the exam(s).

In June 1976, they scored higher in all areas.

In December 1976, the only area which resulted in no difference was Supplies and Equipment. Program graduates scored higher in all other areas.In March 1977, the only area which resulted in no difference was Patient Care. Again, Program graduates scored significantly higher in all other areas.

Pass/Fail Rates - The failure rate is lowest among first time candidates of all groups. The risk of failure increases significantly for all repeat candidates. (see Table 2) Job trained technicians have a higher failure rate as a group. (see Table 3)

TABLE 1

COMPARISON OF MEAN SCORES OF PROGRAM & JOB GROUPS

	GROUP	TOTAL MEAN SCORE	STANDARD DEVIATION	KR 21	KR 20	CONTENT AREA MEAN SCORES: BASIC SCIENCE	PATIENT CARE	ASEPTIC TECH. & ENV. CONT.	SUPPLIES & EQUIPMENT	SURGICAL PROCEDURES
6/76	T	178.6	21.86	.899	.919	46.82	33.81	31.38	28.70	38.06
	P	179.1	21.76	.896	.919	46.60	33.57	31.18	28.85	38.28
	J	170.2	23.38	.904	.926	41.66	31.79	28.54	27.97	35.91
		*				*	*	*	*	*
12/76	T	178.04	22.14	.899	.923	44.48	34.36	31.41	29.04	40.23
	P	178.9	21.93	.898	.921	42.97	34.10	30.82	28.81	40.15
	J	169.8	26.10	.924	.941	38.60	33.23	29.95	28.50	38.14
		*				*	*	*		*
3/77	T	183.4	23.56	.916	.933	50.23	37.08	31.50	SCORED TOGETHER (1) 65.42	
	P	183.77	22.85	.910	.929	49.64	36.51	31.14	65.54	
	J	178.4	24.24	.917	.935	46.19	35.83	30.07	63.37	
		*				*		*	*	

T = TOTAL GROUP P = PROGRAM GROUP J = JOB GROUP (See Page 12)

(1) As of 3/77 Supplies & Equipment and Surgical Procedures are grouped together for Scoring purposes.

* indicates a statistical difference between Program & Job Groups at the .01 significance level.

TABLE 2

PERCENT FAILED - ALL CANDIDATES

	Total	First Time	Repeat 1	Repeat 2	Repeat 3
6/76	50	45	80	83	75
12/76	53	46	75	87	77
3/77	40	36	57	68	100

TABLE 3

PERCENT FAILED

	Program	Job
6/76	46	74
12/76	50	68
3/77	38	49

At the moment, among the formal programs, ranging from nine months to two years, the data indicates there is a higher overall performance rate among two year program graduates. Yet, within each educational group (length of program) there are schools with extremely high and low pass/fail rates. It would appear that the quality of a program (curriculum content) rather than quantity (length) is an important indicator of success.

But, there are other variables to be considered which need further investigation. The quality of the students-do two year (college) programs have higher admission standards thanone year programs? How do one year college programs

compare to one year hospital programs? How do attrition rates of all compare? Are there differences in faculty preparation? These questions have yet to be answered.

Although the failure rate appears very high, according to Dr. Sallyann Henry, of The Psychological Corporation, such rates are not unusual when a new examination structure or format is devised. Many schools take time to adjust their curriculum to the revised exam content outline. In the case of OR Technician programs, many schools have yet to become accredited, i.e., have their curriculum reviewed and approved.

Dr. Henry states that most examinations of this type started off with similar, or higher, failure rates, and it took several years to build up to what the community considered "acceptable" levels. Some groups continue to accept the high failure rates, considering the difficulty of the exam as a way of maintaining high standards.

Comparison of Group Scores by Content Area

This was based on the percentage of items in each major content area with a difficulty level at or below 40%, out of the total number of items in each major content area on the exam. (See Table 4)

TABLE 4

COMPARISON OF GROUP PERFORMANCE
BY MAJOR CONTENT AREA

		Percentage of Items At or Below 40% Difficulty Level				
Group		Basic Science	Patient Care	Aseptic Tech.& Env.Cont.	Supplies & Equip.	Surgical Procedures
TOTAL	6/76	16	9	11	0	11
	12/76	16	9	7	5	8
	3/77	12	2	7	3	10
PROGRAM	6/76	14	9	7	0	11
	12/76	14	9	9	5	8
	3/77	12	2	10	3	9
JOB	6/76	20	11	13	3	11
	12/76	26	9	11	5	8
	3/77	16	2	7	3	12

The most difficult content area on the exam was the Basic Sciences, followed by, in decending level of difficulty, Surgical Procedures, Aseptic Technique and Environmental Control, Patient Care, and Supplies and Equipment. (see also, Table 5)

On all exams, for all groups, the Basic Sciences

had the largest percentage of difficult items. Job trained technicians had a higher proportion of difficult items overall.

Although there are significant differences in total scores (Table 1), the "strong" and "weak" content areas of the exam are essentially the same for all groups.

Analysis of Sub-categories of Content - More in depth analysis revealed that within the Basic Sciences the area of Microbiology was most difficult for all groups, particularly items relating to "structure and function" and "pathogen/nonpathogen"categories. Thirty-three percent of the science items were from this category.

Anatomy and Physiology, with 14% of the science items, was next most difficult. The nervous system (with special senses), muscular and skeletal systems were the weakest areas in this category.

Pharmocology ranged from 6-11% of the difficult items for both groups.

Wound Healing contrasted most from exam to exam, ranging from 0-60% difficulty level for both Program and Job groups.

Medical Terminology had no items in the "difficult" level on any of the exams.

Since knowledge of the basic sciences is fundamental to the application of Operating Room Techniques, it appears this area needs to be strengthened the most.

Surgical Procedures had the second largest percentage of difficult items.

A closer analysis reveals, as one would expect, that "General Surgery" causes the least difficulty. Performance within the "specialties" appears evenly distributed. In all the surgical areas the most difficult items are those related to "instruments, sutures, and supplies" and "pathology". There was nosignificant difference in performance Job and Program groups for these items at or below the 40% difficulty level.

One wonders if a better foundation in the basic sciences, and their application to these areas, would improve performance.

Aseptic Technique and Environmental Control was a "middle" area, not too difficult or easy. The areas which had the most difficult items were those related to "sterilization" and "conductivity".

It also surprised this writer that so many "basic" sterilization items -- principles, methods, agents - fell into the 50-60%difficulty area. Onewould have expected higher scores. It makes one wonder if the schools are emphasizing the "how to" run an autoclave (or other sterilizer) rather than the "why" an autoclave steriilzes; and the factors necessary for sterilization to occur in the various methodologies.

Athough the candidates had no major problems with "Anesthesia" in the Basic Sciences, many of the items in the section on "environmental control - conductivity and explosion hazards", much of which is related to anesthesia, proved difficult. With the increased use of electronic equipment, and the returnto use of explosive gases in many areas, these need further emphasis.

Candidates scored well in all areas related to "Aseptic Technique in General Procedures".

Program technicians scored only slightly better than Job technicians on these items at or below 40% level of difficulty.

Patient Care - candidates performed well overall in this area, with "pre-operative routine" and "transportation" causing little difficulty.

"Positioning", in terms of equipment and variations, posed no problem, but items related to "precautions-hazards" caused difficulty for some, especially among Job trained technicians.

In the area of"Related Nursing Procedures", only "emergency procedures - cardio-pulmonary resuscitation" had items in the difficult level, again, more so for the Job technicians. The basicsof ALL aspects of cardio-pulmonary resuscitation should be familiar to all members of the surgical team.

Although having "Medical-Legal" as a content area had been subject to question by some candidates (in

letters to the Liaison Council on Certification), it proved not to be a difficult area of performance on any exam.

Supplies and Equipment proved to be the least difficult content area with 0-5% of its items falling at or below 40% difficulty level for all groups. All difficult items were related to sutures.

It was interesting to note that although this section was not"difficult" neither was it "easy" (see table 5), with the majority of items falling in the "middle" area (41-80%). "Sutures and Needles" and "Catheters and Drains" posed the most problems.

Comparison of Items in Major Content Areas Classified As "Difficult" or "Easy"

As can be seen from Table 5, the percentage of items at or below 40% level of difficulty indicates a spread of 3-49% in the various content areas. On the other hand, the items at or above 81% indicate a spread of only6-11% over the various content areas.

It appears that, although there are significantly "difficult" areas on the exam, thereis no significantly "easy" area.

Again, the Basic Sciences show up as being clearly the most difficult.

TABLE 5

PERCENTAGE OF MAJOR CONTENT AREA INDICATED AS "DIFFICULT" OR "EASY"

Content	6/76		12/76		3/77	
	Below 41	Above 80	Below 41	Above 80	Below 41	Above 80
Basic Science	49	22	54	15	46	21
Patient Care	12	22	8	19	3	23
Aseptic Tech. & Env. Cont.	15	16	22	18	18	17
Supplies & Equip.	3	19	5	21	3	17
Surgical Procedures	21	22	11	26	29	22
Total # of items	33	97	37	103	28	110

All percentage figures rounded to nearest whole number.

Performance Data, by Option

All items, from each Group, at or below the 40% difficulty level were carefully reviewed from several aspects.

First, the cognitive domain the item covered. Using the taxonomies of Bloom,[14] the most difficult items fell into the following testing objectives:

TABLE 6

"DIFFICULT" ITEMS BASED ON TESTING OBJECTIVE

		Know-ledge	Compre-hension	Applic-ation	Analysis
# of items	6/76	9	2	11	12
	12/76	12	8	7	10
	3/77	7	4	10	8

Second, the Flan R coefficients (r-value) were reviewed. In all but a small number of items they were satisfactory, that is, correct answers correlated positively, incorrect options negatively.

All items wtih questionable statistics were rechecked for accuracy in standard texts.

Third, individual distracter statistics were analyzed and presumptions made about why they were chosen. In most cases it appeared that the distracter chosen was

based on faulty reasoning or application of aprocess, a similar sounding term, or inability to differentiate between parts (of a structure,procedure). Guessing would also account for some choices, one presumes.

All distracters were effective, that is, chosen by some percentage of the candidates.

Items were generally more discriminating (higher r-values) between high and low scoring Job trained technicians than they were between high and low scoring Program candidates.

Repeated questions - a review of all items which were used on more than one examination revealed the following:

1. Very close levels of difficulty, often identical, usually within 3%.

2. The distribution of option performance data was within 2-3% on all items.

Overall, item statistics fell into acceptable patterns - distracters were effective; with satisfactory correlations on distracters, correct answers, and repeated items. As one would expect, items requiring higher levels of cognitive domain caused the greatest difficulty.

Total analysis of the examination seems to indicate an effective, valid, reliable test.

SUMMARY

Summary of Findings

There is a significant difference in overall performance between Program and Job trained technicians. The program graduates consistantly score higher, and this carries down to all content areas of the certifying examination.

Amongst all candidates for the examination the failure rate is lowest for the first-time candidates, and the risk of failure increases each time the exam is repeated. Job trained techicians have a higher failure rate as a group.

Among the formal programs, two-year programs have a higher performance level, although within each educational program-type one can find high and low pass/fail rates, indicating quality of program (curriculum content) is probably a more important characteristic.

High failure rates are not unusual when new examination formats are developed, and it is expected that they will go down as curriculumsare adjusted to the exam content, and more programs become accredited.

The most difficult content area of the examination is the Basic Sciences, especially Microbiology, and Anatomy & Physiology. Wound Healing and Pharmocology also need strengthening.

The next most difficult area, Surgical Procedures,

needs strengthening in the areas of "instruments, sutures, and supplies" and "pathology". One wonders if a better foundation in the basic sciences would improve performance in these areas.

Aseptic Technique and Environmental Control is a "middle" area, not too difficult nor too easy. Difficult items were mainly in the area of "sterilization" and "conductivity - explosion hazards".

In the section on Patient Care, " hazards of positioning" and "emergency procedures - cardiopulmonary resuscitation", could use more emphasis, although as a whole candidates performed well in this content area.

The Supplies and Equipment content area was the least difficult, with the majority of its items in the "middle" difficulty level (41-80%).

Although there are significantlty "difficult" content areas on the exam, it appears there is no significantly "easy" area.

It also appears that, although there significant differences in scores between Program and Job technicians, the strong and weak content areas are essentially the same for all groups.

Overall, item statistics fall into acceptable patterns, with items requiring higher levels of cognitive domain the most difficult.

Total analysis seems to indicate a valid, reliable, effective examination.

It would appear that as more information on the exam, its content, and objectives become available programs will strengthen their curriculums and improve their pass/fail statistics.

Recommendations

Our recommendations fall into three major categories: (1) general guidelines/suggestions that ORT programs might consider, (2) behavioral objectives relating to those areas of the certification which have been identified as "difficult", (3) other factors which need to be considered/ developed, (4) future research.

1. General guidelines/ suggestions for ORT programs to consider:

a. ORT programs should review their curriculums to be sure they reflect all areas of the exam outline content, that is: Are their programs preparing the student to function, at the entry level, in any operating room in this country?

There appear to be programs in some areas which are still directed toward meeting the local hospital's needs and practice situations. This is unfair to the

student in today's mobile world. The Certifying Examination is a national examination.

b. Curriculum content and teaching methodologies should be reviewed to to see that instruction is designed so that the student can understand and apply the principles of theory (why(s), rather than the specific hospital routine and procedure (how to(s).

c. Programs should make use of commercially available self-instructional material in Anatomy and Physiology, Microbiology,and Aseptic Technique for those content areas where time limits make it impossible to cover the material thoroughly in class, or the faculty may not feel qualified to teach it (as in Microbiology).

d. Textbooks used should be up-to-date, and reflect the levels recommended in the Certifying Examination Study Guide.

e. There should be written instructional objectives, and behavioral objectives for the student. Student should be tested adequately to see that they are meeting these objectives, and comprehensive final examinations given to see that they still meet them..

f. Laboratory - Is there a "laboratory",a place where students can practice their skills, and make their errors, prior to clinical participation? Is there a "bridge"

from theory to actual practice?

g. Clinic - In the clinic, is the focus on the learning needs of the student, or the operating room's needs?

Does practice run concurrently to classroom theory?

Is the clinic a place to practice what he has learned, or learn by doing?

Are there planned objectives for each clinical experience, clearly understood by student and staff?

Are the strategies for evaluating performance adequate?

The quality of the clinical experience is determined in large measureby those who provide the guidance. Are clinical instructors qualified through educational preparation and OR experience?

2. Behavioral Objectives relating to those areas of the certification examination which have been identified as "difficult".

The following objectives are based on identified areas of difficulty on the certification examination, and are by NO means intended to cover any content area as a whole. Hopefully, as will be recommendedin (3), objectives for the complete examination will be soon developed.

One should,for the time being, assume that, if one is teaching ALL content areas of the exam outline, that one is performing adequately in the identified "easy" and "middle"areas, and should begin by reviewing those areas identified as "difficult". These in clude the following content areas:

Microbiology - Candidates should be able to:

a. Identify the general characteristics of microorganisms, through knowledge of their classification, morphology, and basic physiological function.

b. Identify common pathogens, and relate their ability to cause disease to their structure and function.

c. Identify the conditions necessary for growth and function of a microorganism.

d. Relate the common sources of contamination and transmission of organisms to the OR environment.

e. Describe the natural and induced protective mechanisms of the body against infection.

Anatomy and Physiology - Candidates should be able to (in the systems listed):

Skeletel System:

a. Identify the structure, and explain the composition of,bone.

b. Identify the different types of bone.

c. Explain the function of bone.

d. Identify the divisions of the skeletal system.

e. Identify the types of joints.

f. Describe the structure and function of joints.

Muscular System:

a. Identify the types of muscle tissue.

b. Describe the characteristics of muscle tissue, and its function.

c. Identify the common, major muscles of the human body, with their main function.

d. Explain how movements of the body are brought about by muscle contraction and relaxation.

Nervous System with Special Senses:

a. Describe the structure of a neuron.

b. Describe the mechanisms of action of a neuron.

c. Identify the divisions and gross functions of the :

(1) Central Nervous System
(2) Peripheral Nervous System
(3) Autonomic Nervous System
(4) Special Senses (structure and function)

Wound Healing - Candidates should be able to:

a. Identify the type of healing one would expect from various wounds and injuries.

b. Define the related terminology of wound healing.

c. Describe the body's reaction to injury.

d. Explain how healing takes place.

e. Identify complications which may result from wounds or injury.

Pharmocology - Candidates should be able to:

a. Define conversion, and compute equivalent units of measurement.

b. Explain the need for accuracy in pouring, measuring, and mixing solutions.

c. Convert commonly used units of measurement within the Metric System.

d. Differentiate between the drugs used in surgery.

e. Identify the indications for use, action, and the precautions to be observed for the drug categories listed on the exam outline (as they relate to surgery).

Surgical Procedures - Candidates should be able to:

Pathology:

a. Describe the regional anatomy of the surgical area.

b. Relate his knowledge of normal anatomy to the pathology present.

c. Explain how the diseased condition affects the body.

Instruments, Sutures and Supplies:

a. Explain how instruments are classified.

b. Identify commonly used instruments by their categories of use/function.

c. Identify commonly used instruments by their universal names.

d. Relate the instrument to the anatomy to which it is applied.

e. Identify categories of suture material.

f. Identify the advantages and disadvantages of use for the various suture materials.

g. Classify the use of suture in relation to anatomical structure.

h. Relate knowledge of anatomy to use of suture, instruments, and supplies.

i. Identify special equipment related to surgery.

j. Describe the use of surgical equipment as it relates to its area of surgery.

k. Be aware of the hazards, and precautions to be taken, with the various specialty equipment.

Aseptic Technique and Environmental Control -

Candidate should be able to:

Sterilization:

a. Define various methods of sterilization.

b. Identify methods of disinfection and antisepsis.

c. Describe the factors necessary for sterilization to occur in the various methodologies.

d. Discuss the process involved in the various methods of sterilization and disinfection.

e. Identify the criteria for selecting a method of sterilization or disinfection.

f. Explain the operation of sterilization equipment.

g. Identify the characteristics of commonly used disinfectants.

h. Be aware of the practices and precautions related to use of disinfectants.

Conductivity:

a. Define static electricity.

b. Describe the factors necessary for an explosion to occur.

c. Explain the rationale for the precautions taken to prevent fire and explosion.

d. Identify the safety measures in the OR environment used toprevent fire and explosion.

e. Recognize the potential for fire and explosion.

f. Describe the role of OR personnel should fire or explosion occur.

Patient Care - Candidates should be able to:

Cardio-Pulmonary Resuscitation(CPR):

a. Define cardio-pulmonary arrest.

b. Recognize signs and symptoms of cardio-pulmonary arrest.

c. Identify steps in process of CPR.

d. Describe the roles of each member of the surgical team during CPR.

e. Explain the use of the electronic defibrillator.

f. List the action and use of drugs commonly used in CPR.

Positioning:

a. Relate surgical position to surgical procedure.

b. Describe the use of the various appliances and attachments used for positioning.

c. Explain the principles of positioning as they relate to patient safety.

d. Identify the potential hazards related to the various surgical positions.

e. Describe the precautions to be taken to protect the patient when he is placed in the various surgical positions.

Supplies and Equipment - Candidates should be able to:

Sutures and Needles:

a. Identify various categories of suture material.

b. Identify the factors which influence the surgeon's choice of suture and needle.

c. Compare the advantages and disadvantages of the various suture materials.

d. Identify those suture materials which can be used in the presence of infection.

Catheters, Drains, and Collecting Mechanisms:

a. Identify commonly used catheters and drains.

b. Describe their use in surgery.

c. Relate the principles of drainage to the anatomi cal part involved.

d. Identify the various commonly used drainage collectiong mechanisms.

e. Describe the application and use of drainage collection mechanisms.

3. Other factors which need to be considered/ developed:

a. A universal minimum curriculum based on the current role of the OR technician nationally, with complete instructional and behavioral objectives. (see also, 4b)

b. Use of identified difficult content areas on the Certifying Examination to recommend changes in current curriculums.

c. Use of identified difficult areas on the Certifying Examination to build continuing education programs.

d. Development of self-instructional programs for OR technicians. To be used to assist candidates with insufficient preparation, or by programs with time limitations, or faculty with limited background (such as Microbiology).

e. Development of self-assessment materials to assist candidates in identifying their needs when preparing for the examination.

f. Implementation of a system of certification maintainence, to insure the continued competence of the practitioner.

g. A reference/resource center at national headquarters to assist candidates/programs in keeping abreast of the latest material for instruction available.

4. Future Research

a. On going evaluation of the certification examination to determine changes in strengths and/or weakness in content.

b. Identification of a national prototype of the OR technician at entry level, and what bodies of knowledge are minimal to safe performance. To be used as the basis for the minimum curriculum suggested in 3a.

c. Other variables related to student performance which need further investigation:

(1) Admission Standards

(2) Attrition Rates

(3) Length of Program

(4) Faculty
  (a) Qualifications
    educational preparation
    clinical experience
  (b) Possibility of requiring certification as proof of competence

(5) Clinical Experience and Supervision

(see also textreferences pp.20-21, and p.34,1g.)

The Operating Room Technician has gained a respected place on the surgical team. In the eight short years of its existance the Associationof Operating Room Technicians has made great strides in gaining recognition

for its members, and instituting policies and procedures to bring its organization up to the level of the other Allied Health Professions. Often it has met with great resistance. Usually it has succeeded. But there is still much to be done, much to be learned by this organization still in its infancy. It is hoped that the results of this project will be a resource tool to assist the AORT in taking yet another step forward.

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APPENDIX

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Association of Operating Room Technicians

National Certification Examination

Outline of Content

I. Basic Sciences — Approximately 30%

A. Terminology

1. Prefixes
2. Stems
3. Suffixes
4. Abbreviations
5. Definitions

B. Anatomy and Physiology

1. Integumentary
2. Skeletal
3. Muscular
4. Nervous including Special Senses
5. Circulatory - blood and lymph
6. Respiratory
7. Digestive
8. Genitourinary
9. Female reproductive
10. Endocrine

C. Microbiology

1. Classification of microbes
2. Structure and function of microbial cell
3. Pathogens vs. non-pathogens
4. Infectious processes
   a. transmission, entry
   b. body responses
      1. local inflammatory
      2. systemic
5. Immune response
   a. antigen
   b. antibody
   c. allergy

D. Pharmacology

1. Weights and measures
2. Drugs used in surgery - action and use
   a. central nervous system agents
   b. hemostatic and anticoagulant agents
   c. antibiotics
   d. diuretics
   e. oxytocics
   f. steroids
   g. emergency drugs
   h. dyes
   i. ophthalmic

3. Anesthesia
   a. pre-op medications
   b. general
      1. methods of administration
      2. stages and planes
      3. agents and complications
   c. regional
      1. spinal
      2. nerve block
      3. agents and complications
   d. local
      1. methods of administration
      2. agents and complications

E. Wound Healing

1. Stages
2. Types
   a. primary
   b. secondary
   c. other
3. Complications

II. Patient Care — Approximately 18%

A. Pre-operative Routine

1. Lab reports
2. Patient Identification
3. Consents
4. Patient assessment

B. Transportation

1. Modes
2. Precautions

C. Positioning

1. Equipment
2. Variations
3. Precautions

D. Related Nursing Procedures

1. Skin preparation
2. Vital signs
3. Emergency procedures - cardiopulmonary resuscitation
4. Catheterization
5. Care and handling of medications
6. Care and handling of specimens
7. Sponge, needle, and instrument counts

E. Medical-Legal

1. Ethical and legal
2. Operating room records
3. Sponge, needle, and instrument counts
4. Operating room hazards related to patient and personnel
5. Specimens
6. Patient property

III. Aseptic Technique and Environmental Control Approximately 18%

A. Sterilization, Disinfection, and Antisepsis

1. Principles
2. Methods
3. Agents

B. Packaging and Dispensing of Supplies

1. Principles
2. Methods

C. Environmental Control

1. Physical layout of operating room suite
2. Operating room dress
3. Conductivity
   a. explosion hazards
   b. temperature
   c. humidity

D. Aseptic Techniques

1. General principles
2. Scrub
3. Gown and glove
4. Draping
5. Special procedures
   a. multiple case
   b. X-ray
   c. cancer technique
   d. bowel technique
6. After case clean-up

IV. Supplies and Equipment Approximately 12%

A. Sutures and needles

1. Classification

B. Instruments

1. Classification

C. Dressings and Packings

1. Types
2. Variations

D. Catheter, Drains, Tubes, and Collecting Mechanisms

E. Equipment

1. Specialty powered equipment - saws, dermatomes, etc.
2. Suction
3. Tourniquets
4. Cautery/Electrosurgical Unit
5. Fiberoptics/Endoscopes
6. Cryothermy

V. Surgical Procedures — Approximately 23%

A. General Surgery

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

B. Gynecology - Obstetrics

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

C. Eye, Ear, Nose, Throat, Plastic

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

D. Genitourinary

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

E. Thoracic, Cardiovascular, Peripheral-vascular

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

F. Orthopedics, Plaster

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

G. Neurosurgery

1. Historical aspects
2. Incisions and prep
3. Positioning
4. Draping
5. Instruments, sutures, supplies
6. Pathology
7. Procedure and anesthesia

Area IV and V will be scored together equalizing approximately 35%

NATIONAL COMMISSION OF HEALTH CREDENTIALING AGENCIES

While in Denver, December 10-12, I received information which I believe should be brought to the attention of all members of AORN and AORT.

As many of you are aware, there was a meeting in August of over forty health career and health related agencies, to discuss the possibility of forming an overall private agency which would be responsible for forming credentialing guidelines for all health professionals. A steering committee was formed, and they met in Washington, DC in early December to formulate the mechanism, enlist the personnel, and plan the methodology which will be voted on at a constitutional convention to be held in late 1977. The new agency would be called (so far) the National Commission of Health Credentialing Agencies.

The purpose of that Commission is recommended to be as follows:

> "To establish standards, grant recognition to certifying bodies and monitor adherances to those standards for certification of individuals participating in health care delivery systems, thus promoting public accountability."

This "main" purpose was further defined by eleven specific functions. I quote three of them here because I believe they may be indicators of the "handwriting on the wall" for ORN's and ORTs (and all health professionals).

1. To promote health and safety for the public through the certification process.
2. To research and evaluate methods for assuring competency after initial certification.
3. To encourage and facilitate the development common and/or collaborative examination programs within a profession and/or among the various health certifying agencies.

This meeting was attended by representatives of ANA, AORN, AORT, AHA, and many State Health and Education departments to name a few.

What does all this mean? First and foremost, I believe it is an attempt by the participating organizations to police themselves and upgrade the credentialing standards before HEW (the federal government) does it for them.

Second, it is an attempt by the commission to bring into focus the validity of standards, policies and roles of credentialing and licensing agencies.

Third, the Commission standards will force the individual practitioner to prove his competency by testing initially, and then periodically in order to prove he is maintaining competency.

Since licensing and certification agencies are participating, as well as the American Hospital Association, it would appear that for OR Technicians mandatory certification is around the corner. For OR Nurses one wonders if the R.N. license will remain as proof of competency since state boards do not include Operating Room in their curriculums or testing. Will a further certification be necessary?

For R.N.s and ORTs it appears that periodic retesting (and possibly mandatory continuing education) is imminent. Food for thought!!

Watch upcoming professional journals, details will be issued as they develop. (September and October Journals).

Claire *

Delegates to National Congress

It is time we choose our Delegates to National Congress. Although our final count is not available at this writing, I expect we will be eligible to have 6 or 7 delegates, plus alternates.

It has been the policy in our chapter to choose our delegates from a list of those who have active membership, know they are going to Congress, and are willing to serve.

These names are presented to the membership at the January meeting. From this potential list, and those names added from the floor, our delegates will be chosen.

Delegates (and alternates) duties should include attendance at:

a. Opening session (Sunday)
b. Meet the Candidates Forum (Sunday)
c. House of Delegates Sessions (Monday, Wednesday & Thursday)
d. Voting for National Offices (Delegates only)
e. Chapter Delegates meeting (to be announced)

Also: There are two forums to discuss issues, which delegates will probably also want to attend. (Wed. 7:30 -9AM & Thurs. 3:10 -4:50 PM)

Written by myself, Claire Liken, to the membership of Long Island Assn. of operating room nurses (AORN) in its Jan. 1977 newsletter. I was chapter President at the time.